



The following is a summary of the vision care services for **State of Nebraska**.
This document is not the Summary Plan Description.

Plan Information

State of Nebraska (Hereinafter, "Employer") has selected EyeMed Vision Care, LLC ("EyeMed") as your vision care services provider (the "Plan"). The Plan, underwritten by Fidelity Security Life Insurance Company, provides coverage for routine vision exams, as well as eyeglasses and contact lenses.

This Summary reflects the Plan that will be in effect beginning **July 1, 2010**.

This Summary is based on the filed insurance documents. If there is a disagreement between the information contained in this Summary and the insurance documents, the insurance documents will govern.

This Summary does not address Plan eligibility. Eligibility decisions are solely determined by Employer.

The EyeMed Network

EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemedvisioncare.com and choose the **Access Network**. You may also call EyeMed's Customer Care Center at **1-866-723-0513**. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceed any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemedvisioncare.com or by calling EyeMed's Customer Care Center at **1-866-723-0513**.

Summary of Vision Care Services PREMIUM Plan

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam	\$10 co-pay	Up to \$40
Dilation as necessary	\$0	
Refraction	\$0	
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	Up to \$55	N/A
Premium Fit and Follow-Up	90% of retail price	N/A
Frames	\$0 copay, plus 80% of balance over \$120	Up to \$65
Standard Plastic Lenses		
Single Vision	\$10 copay	Up to \$25
Bifocal	\$10 copay	Up to \$40
Trifocal	\$10 copay	Up to \$55
Standard Progressive	\$10 copay	Up to \$40
Premium Progressive	\$75 copay plus (80% of charge less \$120 allowance)	Up to \$40
Standard Lens Options		
UV coating	\$15	N/A
Tint (solid and gradient)	\$15	N/A
Standard scratch resistance	\$15	N/A
Standard polycarbonate – Adults	\$40	N/A
Standard polycarbonate – Kids Under 19	\$0	Up to \$5
Standard anti-reflective coating	\$45	N/A
Contact Lenses**		
Conventional	\$0 copay, plus 85% of balance over \$130	Up to \$104
Disposable	\$0 copay, plus 100% of balance over \$130	Up to \$104
Medically necessary	\$0 (paid in full by Plan)	Up to \$200
LASIK or PRK from US Laser Network	85% of retail price or 95% of promotional price Whichever is lesser	N/A
Frequency - based on Service Date		
Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Summary of Vision Care Services BASIC Plan

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam	\$10 co-pay	Up to \$40
Dilation as necessary	\$0	
Refraction	\$0	
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	Up to \$55	N/A
Premium Fit and Follow-Up	90% of retail price	N/A
Frames	\$0 copay, plus 80% of balance over \$105	Up to \$58
Standard Plastic Lenses		
Single Vision	\$10 copay	Up to \$25
Bifocal	\$10 copay	Up to \$40
Trifocal	\$10 copay	Up to \$55
Standard Progressive	\$10 copay	Up to \$40
Premium Progressive	\$75 copay plus (80% of charge less \$120 allowance)	Up to \$40
Standard Lens Options		
UV coating	\$15	N/A
Tint (solid and gradient)	\$15	N/A
Standard scratch resistance	\$15	N/A
Standard polycarbonate – Adults	\$40	N/A
Standard polycarbonate – Kids Under 19	\$0	Up to \$5
Standard anti-reflective coating	\$45	N/A
Contact Lenses**		
Conventional	\$0 copay, plus 85% of balance over \$105	Up to \$84
Disposable	\$0 copay, plus 100% of balance over \$105	Up to \$84
Medically necessary	\$0 (paid in full by Plan)	Up to \$200
LASIK or PRK from US Laser Network	85% of retail price or 95% of promotional price Whichever is lesser	N/A
Frequency - based on Service Date		
Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 24 months	Once every 24 months
Frames	Once every 24 months	Once every 24 months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Additional Discounts

Under the Plan, you may receive benefits for eyeglass frames, eyeglass lenses or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers.

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Medically Necessary Contact Lenses

The Benefit provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus** when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- **Vision improvement *other than Keratoconus*** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you, or your provider, deem contact lenses necessary for other eye conditions or visual improvement.

Savings on Laser Vision Correction

EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at **1-877-5LASER6** to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

Mail Order Contact Lens Replacement Program

You can save money by ordering replacement contact lenses at competitive prices through www.eyemedcontacts.com. The contacts will be delivered directly to your home. Your plan allowance and discounts do not apply to this service.

Plan limitations and exclusions

Your vision care plan contains several limitations and exclusions. Please see your Certificate of Insurance for a complete list.

Sample Savings

The following examples illustrate how your benefit would be applied to the services received at an in-network provider's office or location:

On the Premium plan, if a member chooses to receive:

A comprehensive vision care examination:	you pay \$10.00
A frame up to a value of \$130:	you pay \$0
One pair of lined bifocal lenses:	you pay \$10.00
Ultraviolet coating:	you pay \$15.00
The total cost to the member is:	\$35.00

On the Basic plan, if a member chooses to receive:

A comprehensive vision care examination:	you pay \$10.00
A frame up to a value of \$130:	you pay \$20.00
A pair of single vision lenses:	you pay \$10.00
Standard anti-reflective coating:	you pay \$45.00
The total cost to the member is:	\$85.00

Claims & Appeals

Unless other procedures are required by state law, claims and appeals will be handled as follows.

Submitting Claims

Submit your claim by following the instructions in the sections called “Using In-Network Providers” and “Using Out-of-Network Providers.” FAA will decide your claim within 30 days of receipt. If FAA needs additional time to decide the claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing. The written claim denial may be in the form of an Explanation of Benefits.

Appealing Claims

If your claim is denied, in whole or in part, you may appeal. If your claim has not been decided by the end of the 30-day period (plus 15-day extension, if applicable), you may appeal. The appeal must be in writing and must be received by FAA within 180 days after you receive the written claim denial or after the claim-decision period has expired.

Your appeal documentation should include the following:

- The claim number, or a copy of the written denial, or a copy of the Explanation of Benefits, if applicable.
- Why you believe your vision coverage was misinterpreted or inaccurately applied.
- Additional information from your eye care provider that will assist FAA in completing its review of the appeal, such as documents, records, questions or comments.

Your appeal documentation must be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

If your appeal documentation is timely, FAA will review and decide your appeal within 60 days of receipt. FAA will notify you in writing of the appeal decision in writing.

Authorized Representative

You may authorize someone else to file and pursue a claim or appeal on your behalf. If you do so, you must notify FAA in writing of your choice of an authorized representative. Your notice must include the representative’s name, address, phone number, and a statement indicating the extent to which he or she is authorized to pursue the claim and/or appeal on your behalf. A form that you may use for this purpose will be provided to you upon request. To request this form, contact **1-866-723-0513**.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider’s quality of care, services, materials or facility or with EyeMed’s Plan administration, you should first call EyeMed Customer Care Center at **1-866-723-0513** to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed’s Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

The Insured benefits are underwritten by **State of Nebraska**. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at eyemedvisioncare.com or **1-866-723-0513**.